

## **Culture, connection and belonging: a study of addiction and recovery in Nottingham's BAME community**

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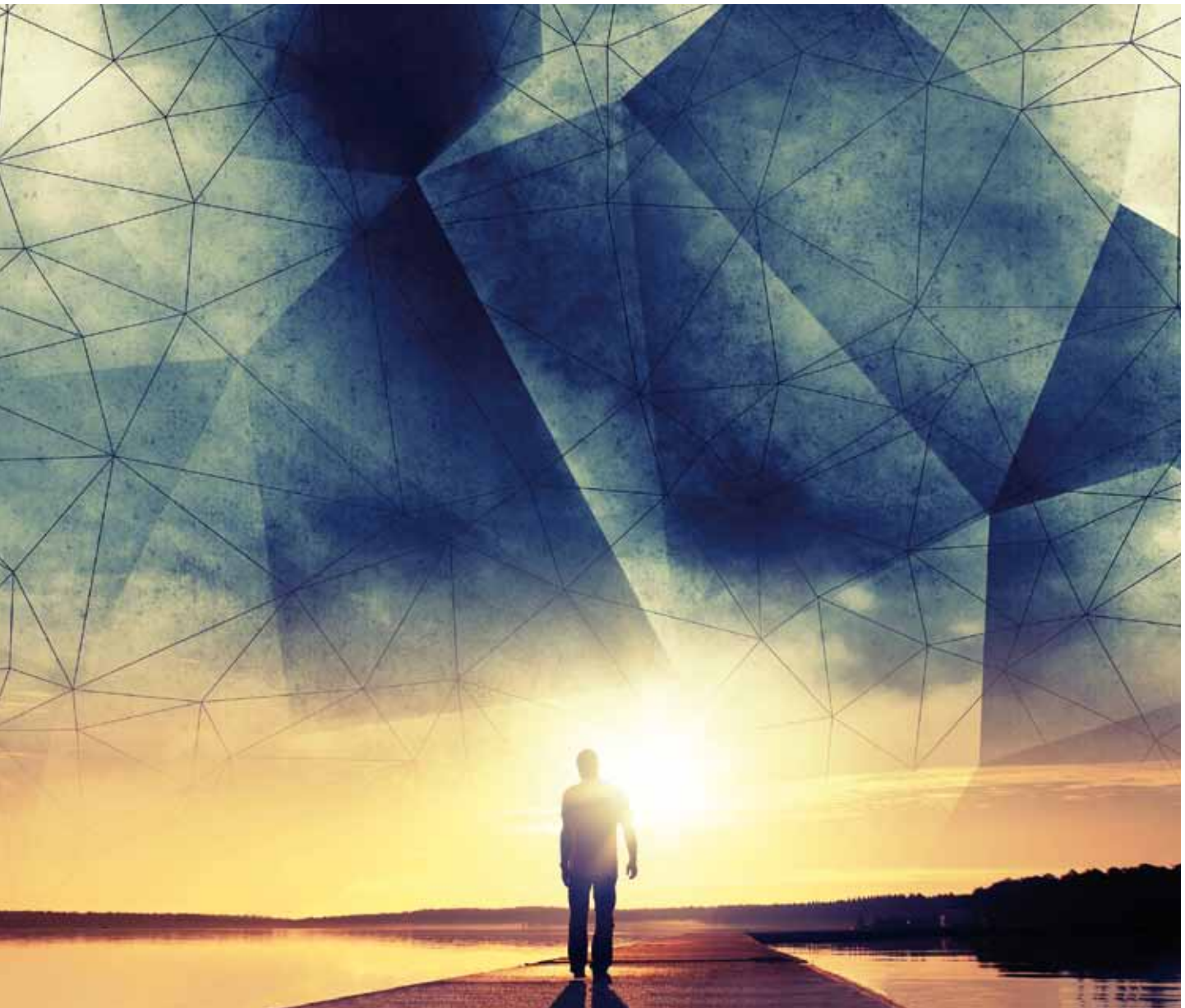
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# CULTURE, CONNECTION AND BELONGING:

A STUDY OF ADDICTION AND RECOVERY IN NOTTINGHAM'S BAME COMMUNITY



**BAC-(IN)**  
2 LIFE

**Lankelly  
Chase**

**Sheffield  
Hallam  
University**

**Centre for  
Regional Economic  
and Social Research**

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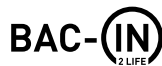


## Acknowledgements

This research has been undertaken in the spirit of collaboration and learning. The authors are indebted to the ten service users who shared their experiences of addiction and recovery so openly over the six/seven month period. We are grateful to our colleague Lindsey McCarthy for her invaluable feedback on earlier drafts of the report, and to Sarah Ward, Melissa McGregor and Emma Smith for their administrative support. Thanks also go to Oliver French at Lankelly Chase who has provided ongoing guidance and support in completing the project.

# BACKGROUND TO THE PARTNERSHIP

This report emerges from a collaborative effort initiated in August 2017 when a diverse learning partnership was established between:



**Lankelly  
Chase**

**Sheffield  
Hallam  
University** Centre for  
Regional Economic  
and Social Research

**BAC-IN** – a peer-led, culturally sensitive drug and alcohol recovery support service based in Nottingham;

**Lankelly Chase** – an independent foundation working in partnership with people across the UK to change the systems which perpetuate severe and multiple disadvantage;

and

**The Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University** – a leading UK policy research centre that seeks to understand the impact of social and economic disadvantage on places and people.

The three partners began to work on 'Project Ahryzen\*' (Horizon) - an action research initiative to explore the experiences of BAME people and other marginalised groups facing severe and multiple disadvantage.

The specific purpose of the two-year partnership was to work collaboratively in the pursuit of the following learning objectives:

**Exploring the lives of BAC-IN peers and hidden experiences of disadvantage:** this strand aimed to focus on the impact of cultural identity, experiences of seeking support, pathways into recovery, and conceptions of a rewarding life.

**Developing and learning about elements of a successful model for supporting BAME communities facing multiple disadvantage:** this strand aimed to understand and communicate the central elements of BAC-IN's support model, including its peer-led ethos and the role of culture, faith and spirituality.

The team was brought together as a partnership of 'diverse equals' with different skills, resources and experiences: BAC-IN's lived experience of addiction, cultural competence and culturally responsive recovery solutions; Lankelly Chase's learning and insights into severe and multiple disadvantage; and CRESR's research and evaluation experience with those people who are often marginalised in research. All three parties were determined to present the authentic voices of BAME people experiencing multiple disadvantage through a co-produced approach based on shared understanding, openness and reflection.

*\*Ahryzen - meaning*

*BAC-IN wanted to create a unique & original name for this project that would not only reflect the essence of BAC-IN's approach but also the multiple components connected to its philosophical roots.*

*The term Ahryzen closely embodies the word horizon but with a culturally mystical & spiritual dimension.*

*The word Ahryzen is derived from a concept of the following key elements: 'Ah' (primordial sound linked to the heart, higher consciousness and to law of manifesting). The word 'ryz' (to rise, to move from low to high). The word 'Zen' (meditative state, to see, to observe, to look).*

*Ahryzen has dual meaning 'arising' and 'horizon' which describes a journey of self-discovery. A journey of awakening from the struggle of addiction and learning to live more consciously through the application of transformative recovery.*

*It also lends itself to a paradigm shift necessary for urgent system & social change for BAME communities whom often have been ignored, underserved and seldom engaged adequately through the mechanisms of policy, commissioning and decision making.*



# FOREWORD

In a society where BAME people's experiences of severe and multiple disadvantage are seldom explored and understood, this report gives voice to those people often stigmatized, hidden and problematised.

By following the personal histories of a group of BAME people in Nottingham and exploring the relationship between addiction, recovery, personal identity and cultural belonging, the report gives a unique insight into the multiple and complex factors which shape people's life trajectories. The stories convey individual struggles, determination and hope. Their own words (in abundance) powerfully bring to life the harsh realities of addiction and the road to recovery.

We have found compelling stories from people who both reflect and challenge the archetypes of what 'severe and multiple disadvantage' means and what services are set up to provide: not just an 'intervention' or a 'programme' to 'fix' people, but a sense of connection, belonging, identification and understanding which recognises shared humanity. The stories show how support models based on positive principles and values – rather than predetermined activities and outcomes – are the essence of transformative recovery, and highlight the need to promote these approaches in an increasingly squeezed and contested commissioning environment.

To us, this report is the central element of a partnership which has proved valuable and educational in many ways – including and sometimes eclipsing the learning aims we originally set out for ourselves.

We hope that others will be able to gain similar insights and develop their own conclusions, and that together we can all build our collective understanding of the complex interplay between disadvantage, culture, faith, ethnicity and recovery.

*Sohan Sahota (BAC-IN), Nadia Bashir (CRESR) and Oliver French (Lankelly Chase).*





# CONTENTS

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<b>1   INTRODUCTION</b>	<b>6</b>
<b>2   METHODS</b>	<b>7</b>
<b>3   FINDINGS:</b>	<b>8</b>
- Life journeys and personal experiences	8
- Sources of support: families, friends and communities	20
- Sources of support: addiction and recovery services	22
- BAC-IN's support model	24
- Faith, culture and personal identity	34
- Participant outcomes	38
<b>4   KEY LEARNING</b>	<b>40</b>
Appendix: Summary of research participants	43

# 1 | INTRODUCTION



*When I went [to BAC-IN] I found something extra there that I didn't get at regular meetings. To my surprise, I felt I could identify on so many different levels, especially culturally... I can come and just be myself, let my hair down, feel understood, appreciated and helped.*

**BAC-IN service user**

BAC-IN is a culturally sensitive, peer-led, drug and alcohol recovery support service that provides support for individuals and families from Black, Asian, and Minority Ethnic (BAME) communities in Nottingham.

The grassroots service was founded in 2003 by individuals in recovery. The BAC-IN model for support is based on the principle of being supported through addiction by those who have experienced addiction. Therapeutic support is offered, one-to-one, as a family or in a group, and abstinence from drugs and alcohol is a central component of the approach.

This report presents qualitative findings from research with ten BAME people accessing BAC-IN for support. Fieldwork was conducted between March and September 2018 and included longitudinal research to understand their life experiences (with a particular emphasis on the impact of cultural identity and multiple disadvantage), histories of substance use and recovery pathways. The research also examines the central components of BAC-IN's culturally responsive support model and compares them with interviewees' experiences of other services.

Wherever possible, quotes (word-for-word) have been used in the report to highlight and amplify the voices of BAME people with addiction; a group seldom heard in research and evaluation activities and society more generally.

Detailed case studies which illustrate the experiences and outcomes for people who accessed BAC-IN for support are the basis of this report, and are published separately in their entirety.



## 2 | METHODS

The **longitudinal research** involved conducting repeat in-depth qualitative interviews with ten individuals every six weeks to track their personal journeys and progress.

Insights from BAC-IN staff and family members) were also gained wherever possible. On ethical grounds, research was only undertaken with those individuals deemed able to give informed consent and not in active addiction. As a result, 10 in-depth case studies were developed over a period of six to seven months. Pseudonyms were used to protect individuals' identities. Appendix I provides more information about the characteristics of each individual.

**Co-production** was central to the research process; three BAC-IN employees were trained in qualitative research skills to each track the journeys of two service users and create case studies. The data were validated by Sheffield Hallam University's research team who also developed four of the case studies.

The following themes were explored with the ten service users:

- Background and life histories
- Services accessed for addiction and recovery
- Experiences of the BAC-IN service.

Every six weeks, individuals were asked about their recovery, how they had been supported, how well their needs had been met, and if anything could be improved. The evidence in the detailed case studies was analysed thematically to draw out the key findings, which are presented in this report. Wherever possible, the findings have been presented using the exact words of service users to avoid sanitising the narratives and unintentionally changing the meanings or gravity of what was shared.





# LIFE JOURNEYS AND PERSONAL EXPERIENCES



*I lost one of my good friends when I was young, he died of cancer and he was in pain constantly and when he died I struggled with it... I tried to basically prove that I could hurt myself more than anyone else ever could and I think that's where it stemmed from.*

**Daniel**



## 3 | FINDINGS

### Life journeys and personal experiences

To understand the ten journeys of addiction and recovery in detail it is necessary to begin by delving into individuals' histories and contextualising their experiences - i.e. when did they start taking drugs and / or consuming alcohol? When did they become dependent and what led to their dependency?

People's narratives revealed a number of reasons behind their addictions, with a prominent one being **Trauma**. Carl started taking cannabis recreationally when he was 15, but it was when he lost his sibling and was in mourning that he began to take various substances including cocaine, speed and alcohol. Patrick had taken a range of drugs as a young man, but the onset of his alcoholism in his twenties occurred as a result of *"my mental health and also losing my gran who raised me since I was born, so she was pretty much my mum"*. Daniel's drug use started at 14 after his friend died of cancer, he recalled:

*"I lost one of my good friends when I was young, he died of cancer and he was in pain constantly and when he died I struggled with it. When he died his dad knocked on the door and was just like, [he] died. I remember thinking what, I never felt like that before. I tried to basically prove that I could hurt myself more than anyone else ever could and I think that's where it stemmed from".*

Trauma was also triggered by other life changing incidents such as **sexual abuse**, which Rajan experienced. He shared, *"I carried those feelings for years and I used to drink on that as well, feeling wrong and shamed*

*and dirty and that was a big reason why I used to drink"*. He consumed alcohol regularly as a teenager and from the age of 16 he became dependent, as he relayed: *"I had to have it as soon as I woke up in the morning, just to deal with life"*. By self-medicating (in his terms) with alcohol and drugs he was able to manage his mental health issues, to cope with social situations and to function in the world with other people. Self-medicating was evident in a second account - Stacey started drinking excessively at 17 due to significant challenges growing up; her mother was an alcoholic and she felt neglected by both parents. What started as fun drinking with friends became more problematic for Stacey, she reported: *"As I was growing up emotional things were happening and I depended on it [alcohol] and used it more as a medication"*. Daniel attempted to moderate his emotions (resulting from trauma, being bullied, and puberty) with drugs and self-harm.

A **chaotic life** was experienced by Steven from a young age, involving prescription drugs with severe side effects, an unhappy school life, and multiple exclusions from schools. By the time he was 18 Steven was depressed, and had already

attempted suicide several times. He had smoked marijuana occasionally at school, but felt that addiction set in later after his **marriage broke down** and his aspirations for a settled family life were shattered.

Kulvinder was in his early 20s when he was introduced to drugs in his social circle, leading to him taking other drugs and drinking alcohol; from an occasional drinker he became dependent. He described how this recreation began to spiral out of control:

*"The circle of friends I met at that particular time, they were smoking cannabis, for example, and I started smoking cannabis, started to enjoy it and then when you do one thing you always do something else, so I was doing ecstasy as well at the same time and I also got introduced to cocaine and crack and things like that but my journey from there got to the point where when I used to smoke cannabis at the same time, drinking at the same time and you might be using three substances [at once]"*.



**Acceptance** by peers and the desire to **'fit in'**, particularly as a minority, was cited by Masood as something which led him onto the road to addiction. He grew up in a predominantly white area, and around the age of 13 he started smoking cannabis with his peers and then went onto selling it. He recounted:

*"I was the only Asian boy in my school; it's a big secondary school. So at the age of 13 that was that peer-led thing, every day I would smoke weed after school I'd be smoking till I went home in the evening... Then I got into selling weed which was a gateway of everything for me, I think if I didn't sell weed my eyes wouldn't have opened to other highs such as ecstasy... MDMA, cocaine, I would have heard about it later on in my life, not as soon, at the age of 15".*

**Peer pressure** within social circles perpetuated drug taking, and in three cases, smoking cannabis led to taking harder drugs - mamba, crack cocaine, and heroin. For example, Dean's 'drug life' (smoking cannabis) began at 12, and this

included selling drugs at school and completely disengaging from education. In his view, access to money and a lack of discipline from his father, who was largely absent whilst he was growing up, steered Dean onto a path of addiction. Edward also described his struggle growing up with a father who was rarely present in his life. Aged 15, he started **using cannabis socially** with friends which rapidly escalated onto using much tougher drugs. His desire to intensify the highs was beginning to take root and early signs of addiction were becoming present, as Edward recalled, *"I would always be the one initiating the scoring and the last one left standing, still smoking and wanting to get another lot of whatever... I wanted more."*

The path of addiction was explained (above) by Dean as the outcome of being an only child with access to money and a lack of discipline. His expectation was to be **disciplined (through physical punishment)** by his father to keep him on the right path:

Interviewer: *"You think that's what you needed [discipline]"?*

Dean: *"Major, major, if he said 'no, don't go out' and I went out I would have got beaten, just cos of what I know of my dad, the times when he did come, I remember... I remember the beatings, what it was for, so I know my life wouldn't have been what it's been if he was there".*

Physical chastisement was discussed by Daniel when describing the commonalities he had discovered with other BAME people when sharing experiences: *"I could be here and a guy talk about a deep Muslim background, people talk about coming from an African background, Jamaican background and the similarities there is like my granddad beat me if I did something wrong, I think a lot of people who come to these rooms [at BAC-IN] is the same".* The harsh realities of both men's pasts were conveyed in their words; however, this was their norm and apparently others' reality too.







*I was the only Asian boy in my school; it's a big secondary school. So at the age of 13 that was that peer-led thing, every day I would smoke weed after school I'd be smoking till I went home in the evening.*

**Masood**







## Cultural norms

When exploring addiction to alcohol, cultural and religious norms about drinking emerged as a notable finding in two accounts; both individuals were of Punjabi Indian heritage. The intention of this research is not to 'pathologise' culture and religion, but to recognise its centrality in people's life experiences, and its importance in the development of personal and social identity.

Whilst only based on the responses of two individuals, thus not generalisable to the Punjabi Indian population as a whole, Kulvinder made an interesting observation about his culture. He shared that alcohol consumption is prohibited in Sikhism, but culturally it had become acceptable within Punjabi Indian communities over time. The cultural norm to drink alcohol during special occasions, such as at Sikh weddings, slowly permeated into Punjabi Indian people's routine lives, becoming normalised and perceived less of a problem due to its social acceptance,

Kulvinder reported:

*"Any Sikh wedding you go to there's always drink there, it's something I think that over time has got into the circle of family and community, back in the old days I don't think it was there, but it's so socially accepted now, if you're going to an Indian wedding it's guaranteed there's going to be booze there".*

Steven reiterated that whilst alcohol had been a part of his culture and a constant in his life since childhood - **his father, granddad and uncle were all heavy drinkers** - he himself hadn't abused it.

These insights help to provide some understanding of why certain excesses that lead to addiction might be overlooked over others and not be problematised (until addiction sets in, at least) due to being normalised.



**CULTURAL AND RELIGIOUS NORMS ABOUT DRINKING EMERGED AS A NOTABLE FINDING**





**NARRATIVES REVEALED A BREAKDOWN  
IN TRUST BETWEEN INDIVIDUALS AND  
SERVICE PROVIDERS**



## Racism and 'belonging'

Racism marred the lives of half (five) of the individuals discussed above and impacted negatively on their histories, and evidence suggests that racism continues to characterise their lives.

It has been the cause of frustration, **feelings of not belonging**, and lack of trust in the workplace, in education, and in encounters with service providers. Racism exacerbated feelings of not belonging. Carl explained how Racism had tarnished his life throughout both childhood and adulthood - *"there's racism as in I'm black, I'm big, so people will instantly [think], you ain't going nowhere, it's a mentality, something I deal with on a daily basis"*. This ongoing struggle, along with the trauma of losing a family member, led to a ten-year downward spiral of mental ill health and addiction. In the present, evidence suggests that Carl is subjected to indirect racism at work; his narrative reveals continuous tensions and power struggles with colleagues.

Edward grew up in the 80s in Bilborough and Broxtowe estates, in a predominantly white area. He was called racist names and taunted because of the colour of his skin. He recalled an incident as a child when visiting his grandmother and going to the local shop, *"to the bottom of the road, there*

*were the guys with the big dogs and the Chelsea boots. The fat guy with the bald head would guarantee racial abuse, some names I've never even heard before in Nottingham these guys were calling us"*.

Of dual heritage, Edward desperately sought to be accepted by the West Indian community but experienced significant **rejection**. He was more comfortable with the white community, as he was raised and educated within that community, although he still encountered racism, he explained:

*"The racism came from both sides so that left me in a situation where I was more comfortable with white folks, because I could just be. But the racial abuse at that end came, but I don't know if it was worse coming from black people, cos I wanted to be accepted by them and yet they were not acceptant"*.

Edward articulated his confusion and desperation to understand who he was within the two cultures that he inhabited by virtue of his descent.

His desire to 'fit in' and belong led to many challenges growing up. Caught up in the tensions of cultural conflict, drugs provided a way out from dealing with reality and instead gave him the temporary sense of fitting in. Edward explained:

*"Part of me is of West Indian descent and I wanted to know what that was about, what did that feel like?... It has an effect and as far as my addiction's concerned, yeah you know, it's confusing man. You don't know who you are, you don't know what's what, and ultimately you take that drug and you fit in with anybody... As soon as I discovered drugs I no longer had to face the realities of what was"*.

In his pursuit for acceptance Edward turned to criminality, creating a persona that would help to raise his worth and self-image, he explained: *"it eventually come to whereby I was around the dreadlocks, selling drugs, making loads of money... drugs, women, cars, money, all that stuff gave me some sort of respect and the funny names stopped and it was big man"*.

# RACISM EXACERBATED FEELINGS OF NOT BELONGING

Despite being white, as a White Irish man, Daniel felt unable to identify with the White English majority around him. His account also highlighted the racism he encountered and his struggle to 'fit in' and be accepted. Like Edward, Daniel related to the **identity crisis** and confusion for those of mixed heritage caused by feelings of not belonging entirely to either black or white heritage:

*"Obviously I'm a white guy who doesn't really identify with the white majority, and that's a big thing because for me, I struggle to fit in anywhere. I've had a white man call me a nigger and I've had a black man call me a cracker. In a mad way, I've probably suffered the same way like mixed race people do in a white household, or the way that mixed race do in a black household, you're not either and the fact is the way I dress and the way I look at times people have said to me I thought you were mixed race. The problem is I'm not, I'm a White Irish man but I can't identify in that community".*

In the aforementioned cases, desperation to fit in is articulated in the narratives; those who experienced racism and/or cultural conflict were acutely aware of being a minority or 'different' amongst their white counterparts, and indeed in Edward's case, of mixed heritage, he also felt different amongst his black counterparts.

Drugs helped numb some of the confusion and emotional distress by creating a false sense of belonging and acceptance.

Steven's chaotic life, described earlier, and unhappy school life was compounded by horrific experiences of racism, which involved violence. Racism did not cease and continued to feature in his life up to the present. During one of his interviews in 2018, Steven shared that he was attacked with a baseball bat on the 3rd of April, apparently named by some as 'punish a Muslim day'. Reflecting on this incident afterwards, he felt that the attack might have been provoked by his appearance; consequently he had a haircut and clean shave to try to look different. As with several others, this case conveys the pressure to try and fit in and belong. Soon after this incident, Steven had a relapse (although he didn't attribute this to the racist attack) but arguably it was likely to have had some bearing on his emotional wellbeing and recovery.

Experiences of racism were revealed in Dean's story while recounting that those who were in positions of upholding the law and providing him security failed to offer protection when it was required, as he commented: *"when you're looking for help and your background comes to the forefront of those you're looking for help from, these*

*are people that are trained to put on a uniform and say they uphold the law, and when they come to help me they didn't uphold the law, they broke the law, they battered me, they beat me up and they looked on".* This incident (under investigation), involving being *"handled excessively by the police"*, resulted in serious injuries requiring regular steroid injections in Dean's hands and ankles to alleviate the pain.

Unsurprisingly, several narratives revealed a breakdown in trust between individuals and service providers more widely, particularly as the perpetrators of racism held positions of responsibility in the statutory sector (e.g. the police, in education, and employment). Consequently, evidence suggested a general reluctance to engage with - and act on - the advice of 'mainstream' service providers, including those in health. Dean's account substantiated this, as did Steven's, in emphasising, *"I can't talk to you [White service provider], you're being like a school teacher calling me a Paki in school"*. This finding has important implications for services that work with BAME people, both in specialist addiction settings and also more broadly.

<sup>1</sup> 'Mainstream' was used by interviewees as shorthand for a range of different local agencies, and could refer to both universal services like Job Centres, and also larger organisations which focus on particular problems like addiction or criminal justice, but lack an advertised element of cultural specificity. 'Mainstream' was evidently used in contrast with 'specialist' approaches.







## Employment and financial hardship

Whilst employment was perceived as contributing to recovery by providing a purpose - a reason to get up in the morning, a distraction from addiction, and income - those who were in work described the precarious nature of it - for example zero-hour contracts.

Carl seemed trapped in a vicious circle; he has a lot of time, energy and enthusiasm, but very little of use to do. He commented, *"If I sit in my house all day every day thinking about recovery and how I'm going to get myself better then it's not going to help...I'll just be sat in a room with my own thoughts getting worse"*. His earlier account highlighted a tension with employers, which led to him being called into work less and less. Previously, his employers gave him three days of work weekly, but now he is rarely called in - sometimes once per month.

As a result of his deteriorating financial situation, and no welfare support, Carl was cutting back on food, household items, and expenditure on his children. The condition of his house had also started to deteriorate, he shared, - *"like my mop broke and I don't have enough money to buy another new mop"* - necessities were prioritised ahead of this.

Routine was recognised as helping to break the cycle of addiction and aiding recovery; hence the importance of securing paid work. Steven reported that he had been busy working on a friend's farm, distancing himself from people with drug addiction who brought additional issues into his life. He commented, *"I'm just trying to stick round good people"*. However, this was informal employment, involving irregular hours.

A lapse in Dean's recovery occurred when he lost a well-paid job through no fault of his own. In addition to the financial damage of losing the job, the other cost was the negative impact on his recovery because when in work he had a purpose and felt *"good... amazing... I was going to sleep and getting up and going to work and weren't going to sleep and getting up and running around town. At the end of the day I was doing the right thing"*.

**THOSE WHO WERE IN WORK DESCRIBED  
THE PRECARIOUS NATURE OF IT**



## What did addiction lead to?

Evidently, when in active addiction, individuals engaged in behaviours that led to multiple problems, which had serious consequences for themselves and others around them. Steven described how his addiction spiralled out of control, leading to **anti-social behaviour** and **violence**:

*“Aged 21, 22 all the way up to now with a domino effect, then I started drinking, then I started smoking copious amounts of marijuana, at least 2oz a week, I was snorting cocaine, I was always on the street, I was involved in anything I could be involved in, whether it be violence, hanging round with the wrong crowd to make myself feel good”.*

The misuse of alcohol resulted in Rajan committing violent offences and robberies and at the age of 19 he received a 3½ year **prison sentence**. After his release, Rajan secured employment as a taxi driver and to work long hours he began to use drugs. It was during this time that he was introduced to crack cocaine, which he used frequently and financed from taxi driving. He eventually lost this job and started shoplifting to feed his growing habit. Life was getting out of control and alcohol and crack addiction was taking over Rajan’s life, leading to more and more contact with the police for shoplifting, and aggressive behaviour, resulting in numerous prison sentences. Rajan relayed his experiences during that time:

*“I was smoking crack in a crack house; I fell out with some people so I started carrying a knife. I was in town selling stolen goods. I still had a knife on me...”*

*I was just desperate most of the time on that drug knowing it's going to run out and I'm going to need more, what am I going to have to do to get more”.*

Edward became addicted to crack very quickly: he felt he could not function without it and nothing else mattered but getting the next fix. The money he was making from drug dealing was quickly absorbed by his addiction. This is when he turned to a different type of criminality:

*“I had to steal money to get drugs, I had to go to any lengths to get it and anyone that got in my way was in danger of harm because they stood between me and the drugs”.*

Aged 22, Dean went to prison for the first time for possession of drugs, and then again at 25 for a much longer sentence. By the time he had served his sentence he had lost relationships with his girlfriend, child, and other family members. Drugs continued to feature in his life and incarceration ran concurrently with it: three five-year sentences and a seven-and-a-half-year sentence, all for supplying or intent to supply drugs. Incidentally, Dean reported that drugs were still easily available in prison.

Individuals experienced **homelessness** in cases where family members, partners and/or friends could no longer tolerate or cope with the impact of addiction on their lives. For instance, Kulvinder recounted how the recurring cycle of substance misuse became intolerable for his family and things came to a head, leaving him no choice but to move out of his parents’ home. This is when he experienced homelessness for the first time. With nowhere else to go, he *“managed to stay in the house that we were decorating cos it was empty”*.

Steven ended up living on the streets and was eventually supported to find accommodation by a voluntary organisation. A breakdown in family relationships also led to Dean experiencing homelessness at the age of 40. For him, this created a deep sense of failure.



# FAMILIES, FRIENDS AND COMMUNITIES

## SOURCES OF SUPPORT:

### Sources of support: Families, friends and communities

The significant efforts of family members and friends to provide individuals with support during addiction were evident in most accounts.

Carl's parents attempted to be supportive, but his lack of attachment to either of them meant he continued to struggle alone. Rajan's family tried to help him with his addiction but their efforts were futile.

Masood's case revealed the misplaced good intentions of his family: their solution for his recovery only served to exacerbate his addiction. Through family intervention, older family members decided that Masood should return to the family's roots in Bangladesh. This didn't help as cannabis was openly available and he used more often. He did however get a break from crack and cocaine during his two and a half month stay.

The concept of **family honour** and how it manifests itself in the day-to-day lives of South Asian people, in particular, had a bearing on how Masood was supported and no doubt has

implications for how other South Asian people are supported by their families during recovery. Actions and behaviours impact on honour leading to **shame** and **stigma**.

Masood relayed that his family had *"got a lot of shame"*. Despite Masood not explicitly connecting family honour with being sent to Bangladesh, it seems highly likely that this was done to avoid the family being shamed or disgraced by how his addiction played out before his wider family and community, and therefore a solution was sought to keep his addiction hidden. Masood's narrative about support powerfully conveyed how family honour acted as a barrier to accessing appropriate support for addiction:

**THE SHAME AND STIGMA  
ASSOCIATED WITH  
SUBSTANCE MISUSE IN THE  
INDIAN COMMUNITY LED TO  
PROBLEMS BEING HIDDEN**

*"With the BME community, there isn't any [support], so you can either go to your doctors, you can go to [a voluntary sector organisation supporting people with substance misuse issues], where you are going to get brushed off, you can go to your local community and you are going to be tarnished, shunned, your family is going to be ashamed, people are going to think you are all druggies, you yourself are bringing down your full family. So could have gone to the mosque to the imam and said I am on drugs even he would have brushed me off... I didn't think there was anything available for anybody in the BME community cos it's very frowned upon, nobody knows, if you're an addict it's going to be hidden".*

There were parallels in Masood and Kulvinder's accounts. Kulvinder reiterated that the shame and stigma associated with substance misuse in the Indian community led to problems being hidden and therefore not being addressed. The overriding concern about what others in the community might think rather than providing help to a family member (with addiction) left that individual unsupported:

*"Being an alcoholic is a shameful thing so we're going to hide it that this isn't in our family and we don't want anybody to know. I always found even in my younger days if anything was going wrong, if I did something or my sister or my brother, my parents were more worried*

*about what everybody else was thinking rather than what the problem was and cos of that state of mind you can't help anybody in your family".*

As a result of his addiction, Steven described being **ostracised** by his own community and not welcome in religious places of worship. He commented, *"I can't even be me when I go to the Sikh temple or church cos people judge you"*. He portrayed addiction as carrying significant shame and stigma within the Sikh community in relaying experiences of loss: *"all my Sikh friends who died, I buried them, not even half of their families buried them cos they're ashamed of them"*.

**A lack of understanding and knowledge** of addiction and recovery within families was also a barrier to accessing support. Kulvinder professed that whilst friends had completely given up on him, his siblings continued to try to help (against the pressures of their own commitments) by signposting him to resources for recovery. However, the gaps in family members' knowledge and understanding of addiction and recovery led to him receiving inadequate support:

*"Even your brother and sister, they see you as addicted to a particular thing, but they don't understand the addiction, the whole process".*

Stacey articulated that her family did not understand what she was going through, and said that *"they just judged me and told me to stop"*. A lack of (or diminishing) support from family and friends occurred as a result of an inability to understand addiction and recovery, or due to no longer being able to support someone whose addiction impacted so negatively on most aspects of family life. In most accounts there was an acknowledgement of letting loved ones down repeatedly, for example, through lies, stealing, domestic abuse, and absence during incarceration.

**I DIDN'T THINK THERE WAS ANYTHING AVAILABLE FOR ANYBODY IN THE BME COMMUNITY**

# ADDICTION AND RECOVERY SERVICES

## SOURCES OF SUPPORT:

### Sources of support: Addiction and recovery services

When tracking the journeys of individuals to understand their use of services, in a few cases it became apparent that many appointments were missed with mainstream providers and therefore it was difficult for individuals to comment on the usefulness of particular services. Reasons for missing appointments included finding temporary work or a lack of confidence in the service in the first place.

Those who had accessed services for support usually spoke about attending Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) meetings. Several accounts highlighted that such meetings were run by ex-BAC-IN staff. A range of feelings were revealed about these meetings, both positive and negative. Primarily, these meetings served to remind individuals of their addiction (this was emphasised by Masood, who felt that *"I still need NA, AA... to hear that I am an addict"*), but also for continuity of support in the evenings and at weekends. Stacey also went to a couple of meetings but couldn't relate to anyone because they were older, white people who had been abstinent for many years.

The AA meetings were ineffective for Steven; he didn't fit in, feeling that *"they are made for white people. When I walk in there I'm made to feel not welcome"*. In his view, these places bring together people who intend on peddling

drugs and those in active addiction - *"the meeting smells of drugs, you've got people who are fighting, giving you dirty looks, people who are looking at you to sell you [drugs] after the meeting"*. However, his experience of NA meetings was positive. He emphasised that the advantage of the NA meetings was that the smaller group size allowed everyone *"a bit more time to speak"*.

Whilst in community secondary stage rehabilitation Rajan started to learn about recovery through the '12 Step' AA programme. He began to attend regular AA recovery meetings; the obsession and compulsion to use diminished and Rajan began to live a clean and sober life. Encouraged by BAC-IN, Rajan accesses Alcoholics Anonymous (AA), but described feeling uncomfortable when there, and stated, *"maybe in desperation I might go there [to AA] but I always have a bad feeling when I come away from there, I feel vulnerable and exposed and just ridiculed"*



*so I don't like going to those meetings. They're not all like that – I go to a few meetings in London sometimes”.*

Masood reached out for support via his GP and accessed a charity that supports people with substance misuse issues through needle exchange and workshops. Similar to Steven's experience of AA meetings, he found that he would go on to use immediately after his visit, or *“find people to use [drugs] with”*.

Other services were accessed for support with addiction and recovery by individuals. It is worth noting that a number of them with a dual diagnosis also received help for mental ill health and continue to do so. Patrick was supported by the dual diagnosis team, and whilst he acknowledged their help, he felt he needed more support to deal with his addiction: *“they used to come to my house and monitor my drinking, I'd get breathalysed, it was helpful to a certain extent but not enough really. I think it was more just like a drop in”*. He accessed an alcohol support service after being discharged from a detox clinic, which was also like a drop-in session, but he didn't derive any real benefit from it.

Patrick currently receives support from a drug and alcohol recovery service in Nottingham, BAC-IN and from a mental health team. The recovery service supported him with his application for rehabilitation, and BAC-IN helped Patrick to establish a meaningful dialogue

with his key worker in the recovery service.

Carl, for example, received support from a psychotherapist and community psychiatric nurse but expressed frustration that both of them failed to understand addiction; he felt this was because they lacked lived experience. He conveyed little confidence in both professionals, and felt that their understandings of addiction were essentially drawn from textbooks. Stacey expressed a similar view of a mainstream support service - *“I didn't feel like I fit in there cos the workers there had never had an addiction, some of them were younger than me, just learned a course and they didn't understand so I stayed away from there”*.

Kulvinder explained that the mainstream service he accessed for support approached recovery and rehabilitation theoretically and systematically, but ultimately failed to connect with him on a human level and to help him make any progress:

*“They're following a certain plan where they're just going to ask you a few questions and then they'll follow it up in a couple of weeks, how are you getting on with this, that and the other, but there's just no connection. I went there a couple of times and I just saw that it's just asking the same questions again, how are you getting on, how's it been for you this week, I didn't feel no benefit out of it cos I still left there feeling the same”*.

Steven frequently saw his doctor for depression and addiction, and was referred to a service for addiction recovery in Nottingham, but didn't feel adequately supported there - in being provided no options for recovery, and instead only the opportunity to offload feelings. Steven recounted, *“It's an appointment and you sit down and talk to somebody for 15 to 20 minutes or as long as you need, they write on their piece of paper and say 'ok same time next week'. That is it. No understanding, no constructive message for me or... we could do this, we could do that, I was just a number”*.

Rajan is currently under the care of a social worker and a community psychiatric nurse. A community support worker was cited by Rajan as being particularly helpful in completing application forms and encouraging him, he commented: *“she's just really nice and she's really encouraging, and I'm getting a lot of help from her at the moment, I'm glad cause, it's been a long time since I've felt supported by professionals within the psychiatric care”*.

# BAC-IN'S SUPPORT MODEL

## BAC-IN's support model

All ten individuals whose journeys were followed for this research were peers at BAC-IN and identified the organisation as their main source of support.

The following section therefore serves as a case study of service provision which is rooted in cultural understanding and connection, and helps to explore what a more inclusive and person-centred support system could look like more widely.

### ONE-TO-ONE SUPPORT

One-to-one support was provided to each individual after their initial assessment and was tailored to specific needs. The support was solution-focused and drew on the previous experiences of addiction of the BAC-IN staff. A **therapeutic** and confidential space was provided for individuals to address any personal and psychological concerns related to addiction, mental health, relationships, confidence and self-esteem. Support was provided in a private space suitable for **reflection**, mindfulness and **personal development**.

It is evident from the case studies that BAC-IN attempt to meet the **holistic** needs of individuals on personal and professional levels; for example, a work placement had been arranged for Carl and he had been introduced to **study groups** for his children's education. His BAC-IN Senior Recovery Worker (SRW) had also helped him to access an assertiveness course to support him in the workplace, and she was assisting him to

compile a CV and supporting his **job search**. Steven was supported to take up two courses for his development, *"routine"* and to keep him occupied. Masood secured employment after receiving help writing a CV, **applying for jobs**, and developing **interview techniques**.

The accounts evidenced that individuals were supported with **debt management** to access **welfare support**, complete application forms, and find **housing**. In Steven's case, the BAC-IN SRW helped him to find housing, going in person with him to keep him calm and positive during the meetings. Individuals received visits from BAC-IN staff when in rehabilitation.

Patrick's narrative revealed evidence of the **advocacy** role played by the BAC-IN team. He recognised that they had done the lion's share of work chasing his mental health team for action in relation to his support. This was an issue that he was struggling to make any headway with, he reported, *"you guys chase it up a lot, and through that chasing up because I, I've found before, when I was trying to chase up before, it wasn't getting anywhere"*.

Clearly, a **person-centred** approach is taken to supporting individuals. BAC-IN's role was conveyed as one of working with each individual service user, outlining the various options for recovery and allowing service users to decide what to take up and arrive at solutions for themselves. This was reinforced by a comment from a BAC-IN SRW when he was asked about Carl's progress:

*"We allow Carl to be, we explore things with him, he has a very different way of looking at things".*

The best interests of each individual were at the heart of BAC-IN's practice and often this involved working closely with other health professionals and organisations to achieve the best outcome for service users. In Rajan's case, BAC-IN worked collaboratively with the psychiatric hospital and Community Psychiatric Nurse, and supported his family during a particularly difficult phase.

#### WORKING WITH FAMILIES

In line with their holistic recovery model, BAC-IN worked closely with family members to increase their understanding of addiction and support. BAC-IN reached out to families, involving them in the recovery of their loved ones. Masood relayed the benefits of this approach:

*"Coming to BAC-IN has helped my family understand what addiction is, they've openly and actively reached out to my family, spoke to my family which has opened their eyes a lot more to what I'm going through".*

BAC-IN met with Dean's mother, at her home, to explain his behaviour. Up to this point, no-one in his personal life understood how he was feeling, he stressed, *"like I say the textbook can't teach you, no-one will ever understand, even my mum living alongside me didn't understand, but without BAC-IN my mum probably still wouldn't understand, she was brought to understand what addiction really is"*.

#### RECOVERY GROUP SESSIONS

The recovery group was accessed by all individuals, usually weekly. This arena encouraged **openness, sharing** of experiences and feelings, and **mutual support**. Whereas 'home' no longer provided a welcoming and comfortable environment for several individuals, the recovery group was perceived as filling this gap. This was evidenced in Kulvinder's account, in which home was conveyed as a place where understanding fell short, but the recovery group was seen as a space where experiences of addiction and recovery were shared and **understood**. Individuals related to one another

better than they did with their loved ones, and the group was perceived as **empowering** people to speak when they felt ready:

*"When you get to a point when home doesn't feel like home it's a very hard thing to get over, but I feel more comfortable coming here cos I feel more of a connection here cos parents still don't understand, they just want everything to be fixed as quickly as that... as I come here I feel more connected with people and the stories that I heard today, that gentleman sitting there that's the first time I've heard him speak which shows you what energy we had here today, today he felt empowered to speak".*

The group session was recognised as being mutually beneficial, Dean reported, *"I can relate to a lot of it so it makes it easier to go there and share your experiences with them"*. The ability to **relate to others** in the recovery group session on the basis of ethnicity and having the *"same outlook on life"* was a major draw of the group for him. He went on to explain that when individuals shared their challenges and achievements, others experiencing similar journeys benefited in realising that they were not alone in their experiences.

**THE TEXTBOOK CAN'T TEACH YOU  
WHAT ADDICTION REALLY IS**



Being able to relate to people in terms of culture, language and experience facilitated open communication during the meetings, encouraging Patrick to speak about his spirituality and mental health **without feeling judged**.

This was vital for Patrick's recovery, he reported:

*"I went to the other meetings... it was like they were talking in a certain lingo, like a certain structure talk, where when I come into the meetings in BAC-IN, you can off load just pretty much anything about yourself. You don't feel like you have to hold back something, for any kind of reason, and when one of the members in BAC-IN spoke one day... about his journey, he triggered something in me which made me realise, one of the roots of the problem was in my own self, so I think they're [recovery group meetings] very important".*

Equally, the group meetings were crucial for Masood as they brought familiar cultures and ethnicities together in one room to share their experiences. He could express himself without feeling judged or misunderstood when talking about certain events affecting his recovery. When asked how sharing in the recovery group had helped him, he stated that this had led to him being able to speak openly and honestly to his wife about his feelings and emotions. Masood expressed a need for more meetings,

## IT WAS NICE TO COME AND BE PART OF SOMETHING

especially in the evenings and other venues in Nottinghamshire as some people found it difficult to access services in the City, especially families.

The **added value** of BAC-IN fostering a culture of openness, effective communication, and encouraging its users to articulate their beliefs and experiences in the group meetings impacted positively on individuals' interactions with family members and other service providers. Patrick, for example, opened up more to other services about just how central spirituality is to his life, including recovery:

*"I've been able to express to some of my CPNs [Community Psychiatric Nurses] differently... talking about my spiritual identity in terms of what I believe in, the things I am going through is related to [the] spiritual".*

**Feelings of belonging** were also expressed by Dean: *"it was nice to come and be part of something and feel part of, it just felt like I was there to make up the numbers at other places"*. Similarly, Patrick articulated the importance of weekly group meetings for his recovery, as he explained, *"when you hear other people's stories [it] actually really does help"*.

The **realisation of addiction** for those **in denial** resulting from hearing other's stories in the group sessions was noted particularly strongly in two accounts - Carl and Patrick's. Patrick reported that he accepted his alcoholism after listening to others sharing in meetings and through regular one-to-one sessions at BAC-IN. Both types of support helped him to acknowledge his addiction and understand what addiction is, he commented: *"when I go to a next meeting I will say, I'm an alcoholic, but I'm trying to recover myself"*.

A sense of **responsibility** to fellow recovery group members underpins the approach to providing and receiving support. The recovery group sessions **open up communication** and encourage those present to **find solutions** from within the group. For example, Kulvinder recalled receiving guidance on what to do when he was struggling with his cravings:

*"One of the sessions here when I found out people are still using I did ask how do you control those thoughts or those cravings, what should I do in those instances and he said pick up the phone and ring one of us and we'll talk about something else, get your mind off it"*.

### THE PEER-TO-PEER WHATSAPP GROUP

The WhatsApp group was described as providing a platform for individual service users to support each other's recovery through sharing useful information and offering encouragement *out-of-hours* during evenings and weekends when access to other forms of support was limited.

Kulvinder reiterated the mutual support function served by the WhatsApp group. In comparison, other services were reported as strictly operating between office hours and were unresponsive to the needs of people with addictions:

*"They'll give you like a hotline number but some of them are 9-5, a drug addict can be active 24 hours a day and if you try ringing one of those numbers you just get 'can you call back at 8am' and by that time you've done what you're going to do".*

Masood stated that having regular contact with BAC-IN staff and peers **anytime and anywhere** assisted his recovery. BAC-IN's WhatsApp group was cited by Daniel as providing a constant source of support no matter what hour, he commented, *"Yeah cos of the group chat, someone's always there. Last night I sat there when I was driving back and I watched BAC-IN peers having a conversation amongst themselves, helping each other at 1, 2 o'clock in the morning, so yeah it's always there whether you choose to accept it or not..."*

## WE CALL THIS OUR FAMILY NOW

*So yeah it's always there, if I need a chat with someone it's always there".*

Dean reported using the WhatsApp group a lot especially during particular periods of vulnerability - *"there may be a time you are feeling really weak and you think you know what I'm just going to have a look back on my WhatsApp cos there's things that I remember on there cos you know it can help... I've been very very close (to relapsing) and WhatsApp saved me"*. Here, the opportunity to look back through previous messages was deemed helpful. Interestingly, a resource (of previous messages and posts) were drawn on during difficult episodes – so WhatsApp acted as a 'bank' of support as well as a source of conversation.

Kulvinder's account revealed that BAC-IN had fostered **interdependency** between the group members to provide mutual support through supportive messages, and posting **calming music** and **positive affirmations**. There was evidence of a strong bond between them:

*"If it makes me feel this good [listening to positive affirmations] then I'm in a group of, we call this our family now... I can help my family and let them listen to it and they might feel good as well. I might send that message*

*now and someone might be going through a hellish time and they listen to that and it's put them in a different frame of mind, a positive frame of mind".*

According to Kulvinder, ten WhatsApp group members were actively engaging daily with the positive affirmations and motivational videos posted. BAC-IN encouraged service users to share their thoughts. Kulvinder reported an incident where one member confessed, *"I'm really in a bad place at the moment"* and he was supported by other group members immediately - *"everybody's either putting a good message up, or a good positive note up, or a video"*.

### THE CREATIVE VOICE GROUP

The newly formed 'Creative Voice' group was an arena for talented individuals to **express** themselves creatively whilst finding an **outlet** for their pressures. The lyrics reflected issues of multiple disadvantage, addiction and recovery. This provided a purpose, as well as a fun and stimulating environment for self-expression. Patrick acknowledged the importance of participating in the Creative Voice group in stating, *"I'll stick to coming to BAC-IN, like doing the things that I enjoy doing, i.e. music, coming to the group."*



*I think one of the main problems at [the hospital] was that the psychotherapist was reading from a textbook, she didn't really know what she was talking about, she's never experienced it [the addiction] so she couldn't really tell me anything about it, she doesn't know what it feels like or what it is to be in this situation.*

**Carl**



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## BAC-IN support contrasted with other services

The research aimed to explore any differences in approach between BAC-IN and other services attended by the peers. In turn, this raises questions about which elements (both in terms of specific practices and overall principles/ethos) we can learn from and the extent to which they can be replicated elsewhere.

When asked about their experiences of services for addiction and recovery, inevitably, all ten individuals drew comparisons between those services and BAC-IN to demonstrate the marked differences. Several of them drew attention to the significance of BAC-IN's **lived experience** and how this contributed to their in-depth understanding of addiction and recovery. In contrast, other service providers were cited as providing more formulaic or 'textbook' responses, which instilled little confidence:

*"I think one of the main problems at [the hospital] was that the psychotherapist was reading from a textbook, she didn't really know what she was talking about, she's never experienced it [the addiction] so she couldn't really tell me anything about it, she doesn't know what it feels like or what it is to be in this situation".*

(Carl)

*"There's one [service] in Derby where they wanted to send me but when you get there they don't understand what you're talking about, it's not that they don't understand, they're more textbook".*

(Kulvinder)

Dean stressed that the one-to-one support at BAC-IN was solution focused and realistic due to it being based on the experiences of addiction and recovery of BAC-IN staff; their **insider knowledge** was perceived as setting them apart from other services:

*"They're still trying to work out how to manage people in other places, whereas here [at BAC-IN] they know what they know, they don't work from a text book, they're working from life [experience]"*.

BAC-IN employees' thorough understanding of recovery was situated in their own experiences of addiction. Kulvinder succinctly conveyed why BAC-IN was suited to meeting his needs rather than mainstream services:

*The people who I was speaking to through the NHS, they're just people who have studied it, they haven't really gone through it, and I think that slight disconnect between the two has made this place [BAC-IN] more appealing...it doesn't matter what I say or how I say it they know straight away [what I mean]. When I speak to [other people] they were like okay that's fine but they didn't get it... so if they don't get it I don't see the point in going.*

The friendly and **welcoming** nature of BAC-IN staff was highlighted by individuals as being markedly different from their experiences of other services accessed for support. For example, after some reluctance Kulvinder went to BAC-IN for the first time and was immediately taken aback by the warm welcome, which quickly put him at ease and allowed him to open up:

*"When I walked in and saw him, he gave me a hug, how's it going and puts you at ease straight away and then he basically told me about BAC-IN, what they're all about, where it started, what his journey was and after speaking to him I was a bit reluctant to open up fully cos it's the first time I've met him, but as soon as I started talking I couldn't shut up, I had to literally get everything out".*

The **sincerity** of staff was valued by Dean. BAC-IN was a constant source of support in his life regardless of how many times he relapsed. In his view, the service was accessible and welcoming, "you get spoken to and related to ...the second you walk through the door".

This was contrasted with the experience of accessing other recovery and rehabilitation services: *“other services you’re sitting there queueing and no-one’s come out and said hello, you go to the receptionist and you’ve got to queue... BAC-IN offers more...it’s done in a sincere way, it’s a massive difference, it’s not a case of we’ll see you then”*.

AA and other recovery meetings were portrayed in a different light by Steven who stated, *“when I walk in there I’m made to feel not welcome”*. The cold and clinical setting of a mainstream service for recovery was recounted by Daniel as leaving a negative impression on him, he explained, *“you get locked out of the room, you’re sat in a little entrance way and you can’t go past that point. I just didn’t like the service, I am the way that I am and they want to make you feel a type of way”*.

BAC-IN, on the other hand, was likened to being amongst **family** where each individual was afforded respect. Patrick described it as being *“like a family unit”* where he felt *“comfortable”* and Dean expressed a *“sense of relaxation”* at BAC-IN; a place where he could wind down and relieve some of his pressures.

Occasionally, after recovery group meetings, culturally appropriate food was put out for service users, sending the message to them that, *“you’re welcome, you’re us, smell it, remember it”*, and this had further significance for Steven

who explained that it reminded him of the past when he was in a better place, *“smelling it sometimes will remind me of my nan’s cooking food and I’m in her place free of drugs”*.

Three individuals articulated how other services had dealt with them in such a way that they had *felt like a number*, not a person. In an emotional interview, Steven recalled how he was treated by a service provider; there was no understanding, no constructive message for him, nor any options, he stated, *“I was just a number”*. In contrast, BAC-IN contacted Steven regularly to see how he was getting on, face-to-face and over-the-phone. He explained, *“they’re just seeing if I’m alright... did I enjoy going to the meeting, have I got any issues, and if that meeting is the right one for me”*. BAC-IN support varied according to each individual worker’s skill set - for example, the trained psychotherapist focused on meeting Steven’s emotional needs.

Kulvinder’s comparison of past experiences of addiction and recovery services with BAC-IN revealed that in *“[previous services] it was more of a numbers game, get you in, get you out. Every week it was the same process...most of the people, they’re in there for 15/20 minutes and they’re straight out the door...after the meeting [BAC-IN Recovery Group] we’ll still be here an hour later chatting away”*. A **feeling of belonging** was expressed which

was echoed by Dean, *“it was nice to come and be part of something and feel part of, it just felt like I was there to make up the numbers at other places”*. He acknowledged having received support in some form from other recovery services in Nottingham, but fundamentally the *“realisation [to change] came through BAC-IN”*.

With **total abstinence** perceived as fundamental to recovery, BAC-IN was felt to have the interests of those with addiction at heart, in contrast with strong feelings about ‘mainstream’ reliance on prescriptions to help wean people off drugs; such approaches were felt to be ineffective and even disingenuous. Steven expressed his strong opposition to this, in stating, *“stop giving people drugs to come off drugs, support them [with alternatives]”*. When Daniel sought help from his GP and mental health services, he was disappointed that medication was the only option he was given, he shared: *“you go to a doctor and they put you on medication, that’s another form of addiction... they gave me the medications and nothing changed anything so I stopped taking them”*. Patrick reiterated that most of his GP appointments had resulted in prescriptions for drugs, whereas, in his view, BAC-IN’s approach to treatment differed. The desire to remove any type of drug dependency emerged as a theme from several interviews.



Individuals sought alternative treatment to medication and BAC-IN was recognised as providing different options such as one-to-one and recovery group support, and counselling. BAC-IN, however, recognised the importance of medication for some individuals' recovery - for example, in relation to mental ill health - and encouraged them to take it. The commitment to total abstinence was focused on illegal substances and alcohol.

Of note, while BAC-IN's model for recovery involves complete abstinence, relapses are worked through. Dean, for example, was not denied support for smoking cannabis, and he felt that *"no matter what, they try and help you"*.

From the initial assessment, BAC-IN put support into place quickly. Patrick relayed that after his first appointment a second one was booked for the same week. When Steven reached out

to BAC-IN he was seen *"within the hour"* and registered for a counselling session, and regular reminder calls ensured that he didn't miss out on the support that he required, preventing problems from escalating.

In Masood's experience, the quick and easy appointment system at BAC-IN was different to mainstream services. He recollected leaving messages at the offices of a service and would hear from them after a few days. Moreover, he didn't get the support when he needed it most, if it was out of office hours:

*"I wouldn't be able to call them cos the reception hours are only open till 1pm, whereas what I was feeling was at 9pm and I got in touch with BAC-IN and they carried on texting me till 10.30pm. I wouldn't have got that anywhere else. I can't call the GP, I can't call anybody else"*.

Kulvinder also took reassurance in knowing that he had access

to **round-the-clock support**, including over-the-phone should he need it. Similarly, Patrick's account revealed that he could access BAC-IN at a time of need - *"but it's more open here... I can come here anytime and sometimes that you going through certain things and nobody can help you, but it's always good to know that if you need to, you can come here."* Evidently, when individuals were at their most vulnerable, access to BAC-IN was swift. Masood articulated that when he experienced strong urges to use he was able to access BAC-IN immediately:

*"My wife went back to her mum's for 5 days and there my head is planning and scheming on where to rob, which till to get money and how to rob and just have a massive blow out. I've obviously not done that. I came to BAC-IN, I told them about it... [they] helped me get my head back on track"*.



Daniel explained how BAC-IN was **responsive** in his time of crisis: *“the day I phoned [BAC-IN], I got the number and I told him I’m a mess, I need to come and see someone, I was in the door and in a room chatting to someone within 15 minutes, that probably saved my life, saved me from doing summat stupid that day, without a doubt. Within 15 minutes of me making that call I was here”.*

Having lived experiences of addiction and recovery, BAC-IN demonstrated a **sensitivity** and understanding when dealing with service users, appreciating the complexity and chaotic nature of their lives. The flexibility in their service was responsive to the disorder that often goes hand-in-hand with addiction. Daniel explained that due to the transient nature of his job, or the effects of addiction, he would sometimes miss appointments with his counsellor or the other recovery service he accessed for support, and their response had an impact on him that caused him to self-harm or relapse:

*“They used to make you feel a type of way... I’m a sensitive type of fucker, you give me a wrong look I’m going to be at home chopping chunks out myself and sniffing cocaine, you should understand that as an addict, and they didn’t, it was a problem for them, they’d wasted time and effort on you, well you’re an addict, you’re gonna fuck up... You guys just get it, you’ve been there, and they seem to forget it in other services, you’re an addict, you still are man, you can slip like all the rest of us”.*

Both Daniel and Rajan shared that BAC-IN had helped them to deal with deep-seated issues that other services had failed to do. For example, Daniel had experienced an outpouring of emotions resulting from lifelong issues that hadn’t been addressed until recently. He reported, *“of late the way this service is making me feel, I’ve been crying and crying and it’s cos I’ve not addressed this shit for so long”.* Rajan felt he couldn’t talk to the psychiatric team about his addiction to sex for fear of being judged: *“it’s frustrating me because I still have lust issues... Well, you know what, I can’t talk to the team at the hospital because they’ll judge me and they’ll say ‘right you’re not acting quite right’, so I’m... yeah I’m talking to [support worker at BAC-IN], you know, here... the way BAC-IN works for me is that, get here and be honest and get well... quick”.*





# FAITH, CULTURE AND PERSONAL IDENTITY

RELIGION AND/OR SPIRITUALITY  
PLAYED A FUNDAMENTAL ROLE IN  
MOST SERVICE USERS' RECOVERY







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## Faith, culture and personal identity

Research participants' views on what constituted 'good' or 'effective' support could focus on the various practical issues outlined above, such as accessibility and speed of response; but in the interviews there was also a strong emphasis on much deeper themes around belief systems and human connection with others.

### RELIGION AND SPIRITUALITY

Religion and / or spirituality played a fundamental role in most service users' recovery, acting as a source of support and a positive force.

Carl articulated that Christianity was helpful during transition from addiction to recovery; he shared, *"I started going to the church again, it was just something I did cos it was helpful for me"*. He felt better within himself when immersed in spiritual practices such as **meditation** and **exercise**. Kulvinder reiterated *"I'm not as agitated as I used to be, I'm more relaxed, I've started to meditate more, which is helping me a lot"*. Patrick's faith and spirituality helped him through his psychosis episodes, *"I went outside and just prayed really hard, and with conviction and I believe that really and truly it worked... the voices just fled"*.

Steven shared that although he was born into Sikhism he was more spiritual than religious. Meditating, listening to positive music, and watching video recordings of *"positive spiritual people"* as well as walking lifted his mood and helped him maintain a positive outlook on life. The various spiritual practices helped Steven establish a routine, have a

**positive mind-set**, and, on the whole a more positive lifestyle:

*"Every morning I wake up and I'll talk to a higher power, may it be someone who I really loved who passed away, for me it's my nan, but when I first started it was my mum, certain people I looked up [to]"*.

Edward's faith awakened him to a new reality: eating good food regularly, exercising, giving up coffee and cigarettes, the *"junk music"* is gone and even the use of vulgar language is going. Rajan, originally from a Hindu background, embraced Christianity as his primary faith. His narrative revealed the significance of faith *"to cope, and move forward"* in his day-to-day recovery, particularly in helping him to keep a check on his behaviour.

Similarly, Kulvinder reported that spirituality helped **police his thoughts** which in the past had led him astray: *"I've been meditating a lot more, I've been listening to quite a lot of mantras when I go to sleep...it's almost like I've got thought police in my mind now"*. Previously, anything related to drugs, whether through music or TV, would trigger his mind to wander and consequently he would *"start planning"* how to get his next fix.

In Daniel's case, religion was described as policing his thoughts to remain on the path of recovery: *"I feel like I'm on my own and then I have these highly religious moments... I remember the moment where I thought I don't want to sniff any more, that feeling of not wanting to [be] around them types of people... that to me is godly, that's the only thing that helped me stop is them thoughts"*.

Crucially, BAC-IN not only understands the role of religion and spirituality in many BAME people's lives, they perpetuate the benefits of religion and spirituality for **hope** and **strength** during recovery for those of religious inclination. Individuals who previously felt judged expressing their beliefs and spirituality articulated an acceptance and understanding at BAC-IN, for example, Patrick commented, *"I can speak freely and not think 'shall I not say anything to that person because they are not going to understand?' or not think I am mad or something, because a lot of people do think you're mad because you speak about spirituality."* Of note, those without religious or spiritual disposition are respected and supported without any pressure to 'conform'.

Stacey appreciated the inclusivity of BAC-IN and the opportunities that they created for her to identify with others from religious backgrounds, commenting on the recovery group she shared, *"It's nice to see young people and a lot of religious people speaking about their religion and how it affects their religious beliefs. In the past everyone I've met they were never religious, so it's nice to know that nearly everyone in this room kind of comes from religious backgrounds"*.

#### THE IMPORTANCE OF IDENTIFICATION

Of all the factors that drew individuals to BAC-IN, **'identification'** with service providers and users was of most significance. Identification occurred on a number of different levels. In particular, it was felt crucially important for service providers to have **experienced addiction**. BAC-IN's peer-led model of support was valued highly, and contrasted with recovery services where staff had no first-hand experience of addiction and recovery:

*The chap I went to see in Derby, he's just basically done a drugs counselling course, done his exams, went to university, I'm not disrespecting what he's done but he's more textbook, he'd follow certain guidelines or things to look out for but he wouldn't understand someone [with addiction]... but here it's different, cos we're all one family, we're all addicts in some form, we understand each other a lot better so you can attack the problem better together.*

(Kulvinder)

A huge importance was attached to BAC-IN being a **peer-led service**. Steven emphasised that he could place his faith in people he knew had experienced addiction and recovery themselves:


*"Cos they've been through it. This is what I've always said, if I'm sitting with the so-called best NHS drugs worker, they come out of uni and sit there, never lived on the streets... they've never even took drugs, they've no identification, they know nothing".*

During his interview, when asked who was best placed to provide support to those with addiction issues, Edward reiterated, *"the best thing for any addict is another recovering addict, I think that is without question... recovering addicts need recovering addicts, because no one else understands an addict like an addict"*. Likewise, Rajan commented, *"I know that the best help you can get is from another addict, someone who's been there and that's a fact"*. Dean recalled that the turning point in his life was when he made contact with someone from BAC-IN whom he strongly identified with and trusted, where there was a mutual understanding between them. Knowing that people with addiction had transformed their lives was **motivational** and **inspiring**. This was highlighted in Daniel's account, *"so yeah you need BAC-IN and peer group and friends, people who've been through it and have been out the other side, otherwise you don't get nowhere"*. Stacey echoed this sentiment, *"it's nice to know you can go to the other side"*.

The ability to identify with BAC-IN staff and service users on the basis of **ethnicity** and **cultural similarities** contributed to a feeling of belonging for Dean, Stacey and Rajan. Masood, who expressed frustration in his interviews about the lack of cultural understanding amongst service providers, felt that at BAC-IN he could express himself freely without the need to explain himself when talking about his culture, practices, issues of shame and honour. He reiterated, *"Caucasian people don't have an understanding of what's happening in my home, whereas I can say it in BAC-IN as they just understand and share the humanity, the hierarchy, the honour"*.

Cultural identification allowed BAC-IN workers to not only share and understand commonalities of addiction and recovery with service users but by virtue of their ethnicities they were closer to their experiences of multiple disadvantage. For example, Steven's life had been riddled with racism and exclusion. In Steven's view, BAC-IN workers (of various BAME backgrounds) were easier to trust due to his previous experiences of racism - *"I can't talk to you [White service provider], you're being like a school teacher calling me a Paki in school"*.

**A HUGE IMPORTANCE WAS ATTACHED TO BAC-IN BEING A PEER-LED SERVICE**



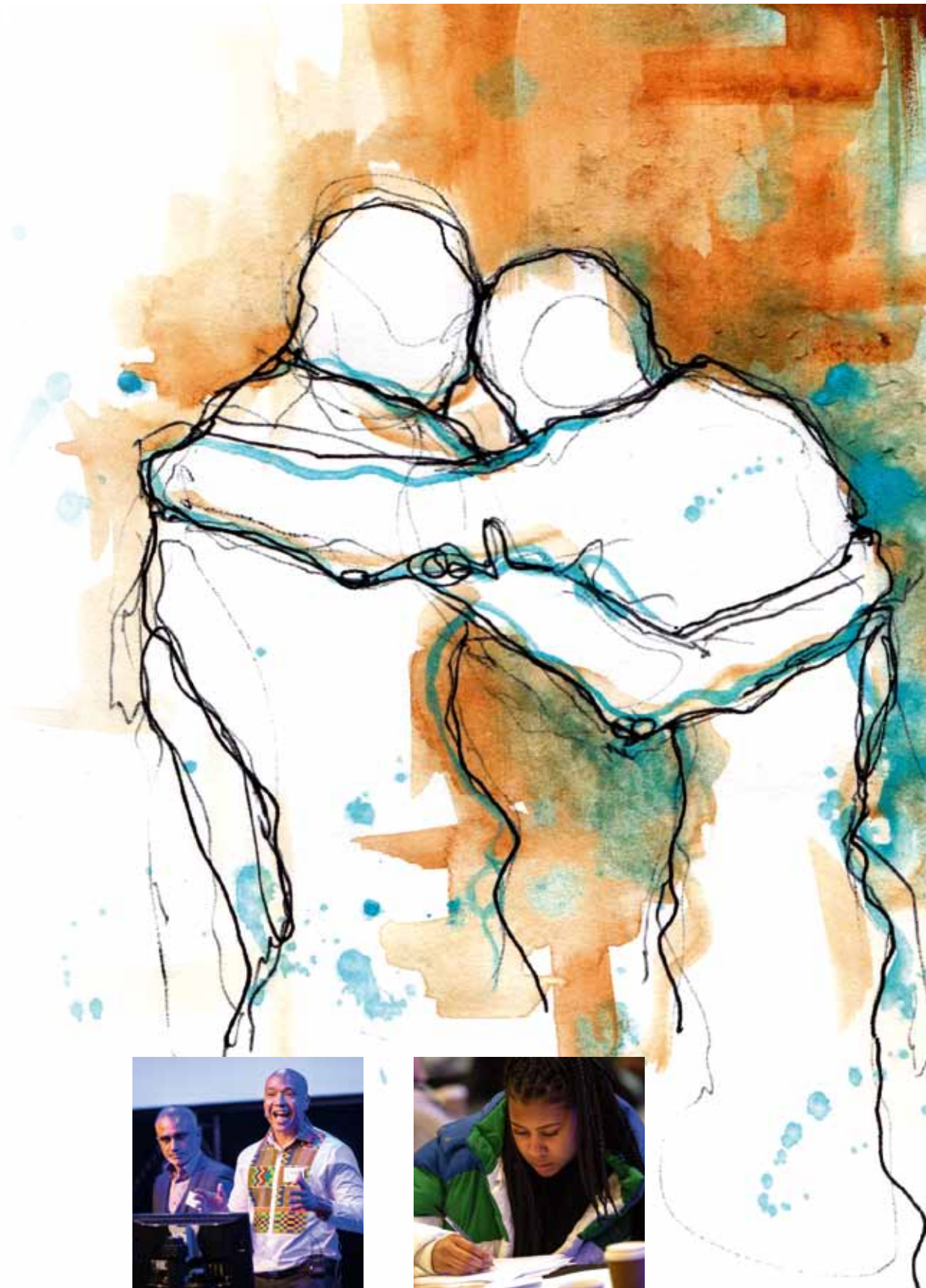
'Identification' was not purely on grounds of race or cultural background, however, illustrating that cultural sensitivity is not the same as exclusivity. For example, Daniel's struggle with his own identity made it difficult for him to identify with the white majority, but he was able to identify with the diverse range of people at BAC-IN and feel accepted: *"I went to BAC-IN and it's how I spoke innit and everyone's sat there nodding and smiling and that was it, I thought yes, this is it, I can get better and I can talk about it and people will understand"*. Patrick also appreciated the diversity within the BAC-IN recovery group, and over time developed the confidence to open up and share his experiences.

Of importance to Stacey was the ability to identify with BAC-IN staff and service users on the basis of addiction, culture and **age** - *"It's good cos I don't feel odd, I feel like I fit in cos everyone's from different races and different ages as well, not everyone's old"*. In her interview, she had cited age as a barrier to fitting in in other recovery meetings.

**THE ABILITY TO IDENTIFY WITH BAC-IN STAFF AND SERVICE USERS ON THE BASIS OF ETHNICITY AND CULTURAL SIMILARITIES CONTRIBUTED TO A FEELING OF BELONGING**



# PARTICIPANT OUTCOMES





## Participant outcomes

Whilst recovery was conveyed as a lifelong journey with ups and downs, which were reflected in the case studies, each individual readily accessed BAC-IN during episodes of relapse and were quickly supported to prevent an escalation. They expressed strongly that they had most confidence in BAC-IN as being responsive to their needs.

Encouraging progress was captured over the course of the research in a number of cases. For example, Patrick had significantly reduced the amount of alcohol he consumed from 8 cans of beer to 2 cans per day and had switched to alcohol of half the strength. He had encountered a few psychotic episodes which set him back with his mental well-being, but continued to access BAC-IN at least once a week.

After reaching over 6 months of abstinence from cocaine, Daniel had a recent relapse and explained that this experience affirmed that he *“didn't enjoy using”*. He also described how he had made changes within his social circle to keep company that would allow his recovery to be sustained.

We learn that Masood had been clean for 140 days and an inspiration to many newcomers in the BAC-IN recovery group meetings. He had secured a full time job and completed his probation period.

Whilst Dean had had a troubled journey over the past six to seven months, he had come to the realisation that rehabilitation outside of his community was necessary for his recovery and was waiting for a space to

become available. Meanwhile, BAC-IN was his only source of support. He continued to access the recovery group meetings and personalised support at BAC-IN with his partner.

At the point of his final interview, Rajan has been clean for three and half months, but had been isolating himself and keeping a low profile. He had experienced health problems and a lot of stress. He continued to access BAC-IN - *“I feel a lot stronger when I'm connected to people here [at BAC-IN]... in the past years this is the only thing that has worked... [I] spend more time here than on my own”*.

Steven withdrew from the research midway due to multiple and deep-seated problems. He moved away from Nottingham temporarily, but returned recently and is being supported by BAC-IN - the only service that he will access for support.

Kulvinder's recovery followed an upward trajectory even though he had a period of denial. Having gained the trust of his family, he began to take on work and caring responsibilities. He perceived himself as being a valuable peer where he was *“giving something back”* by supporting those new to the service through offering hope.

He was continuing to post positive messages and videos on the BAC-IN WhatsApp as a form of mutual support for new and old members.

Despite his challenges with his mental health, employers, and acquaintances, Carl had been meditating, sleeping, and going to the gym, and this resulted in positivity. Time alone was helping his recovery. Consequently, his visits to BAC-IN were irregular. BAC-IN were understanding, knowing that Carl would get more involved when he was ready.

Edward had been clean for just over six months when he had his last interview in rehab. He had physically repaired, started to grow spiritually and was starting to feel a bit more stable. BAC-IN continue to visit him regularly and maintain contact with him.

Having secured employment, Stacey stopped engaging with BAC-IN. She did continue to receive support over-the-phone until she decided she was stable enough to withdraw. She is aware that BAC-IN can be accessed for support anytime, should she need it.

# 4 | KEY LEARNING

This report has presented the findings from qualitative research with people accessing the BAC-IN drug and alcohol recovery service for Black, Asian and Minority Ethnic (BAME) communities in Nottingham.

The journeys of BAC-IN peers were tracked to understand their recovery pathways; their engagement with services and other support networks; and their life experiences, including the impact of cultural identity and multiple disadvantage. The research also aimed to explore the central elements of BAC-IN's support model and how well it works in helping people recover from addiction. From the perspectives of the authors and the research participants, the key learning is as follows.

## 1. Causes of addiction

Research participants identified a number of different factors which they associated with their routes into addiction.

### A. SYSTEMATIC EXPOSURE TO RACISM

Racism was described as being present throughout people's lives, including in communities, in schools, in the criminal justice system, and in the workplace. Racism led to feelings of not fitting in, and the desire to 'belong' resulted in individuals going to great lengths, including engaging in illegal activities such as drug taking to feel accepted. For people of dual heritage, a confusion and desperation to understand the two cultures they inhabited, coupled with the desire to be accepted - exacerbated by racism - often led them

to drugs. This provided a means of dealing with the cultural conflict and a way to escape an often harsh reality. Clearly, those subjected to racism were acutely aware of being a minority or 'different' amongst their white counterparts and in such cases this resulted in confusion and emotional distress – for some, drugs and alcohol helped numb these feelings by providing a false sense of acceptance and belonging.

Many problems were first identified during adolescence, when peer pressure could have a role in the initial and continuing use of drugs. In a few narratives, disengagement from education was attributed to racism and not fitting in. As a result of disengagement from education there was some evidence of low literacy which carried through into adult life. Inevitably, this gap in basic skills impacted on employment prospects, the ability of individuals to understand their rights and responsibilities, and created difficulty in negotiating and interacting with agencies in day-to-day life. A wealth of evidence highlighted that several individuals were highly dependent on support services for advice and guidance relating to education, employment and housing.

### B. TRAUMA

Trauma was central to understanding people's journeys, both in terms of ongoing experiences of discrimination and oppression, and also major life events leading to shock and distress. Three of the peers spoke in particular about the loss of a loved one and another reported that their substance use was triggered by sexual abuse. In a couple of examples, trauma was exacerbated by existing mental ill health, but in other accounts there is evidence that mental ill health was itself caused by chaotic life events and was diagnosed prior to the onset of addiction.

### C. NEGLECT AND OTHER ADVERSE CHILDHOOD EXPERIENCES

Instability, neglect and parental alcohol use were reported as sources of emotional problems. Lack of parental guidance emerged as a significant theme when discussing early life experiences. The research participants were mainly men, and as such there was discussion of the nature of fatherhood – including not being there enough (or at all), or in the use of physical punishment – and its contribution to personal insecurities, for example around masculinity.



Self-medication with drugs and/or alcohol provided a means of moderating emotions to continue functioning amid the chaos and distress. Emotional problems resulting from a range of factors (including bullying, the death of a loved one, puberty, racism) were moderated with drugs and/or alcohol by individuals from a young age.

#### **D. SEVERE AND MULTIPLE DISADVANTAGE**

Individuals' experience of long term complex disadvantage was central to understanding their use of drugs and alcohol. The accounts revealed the presence of a range of interconnected factors, including trauma, mental ill health, poor family relationships and parental neglect, racism, lack of education, and several more - that interacted with addiction pathways (and with each other) in different ways. It is helpful to understand these issues as part of the same tangled web of people's life experiences, rather than issues or events which 'cause' one another in direct or linear ways.

## **2. The importance of culturally tailored responses to addiction**

We found that institutional racism continues to feature in the lives of people experiencing addiction. In some cases this led to a lack of trust in mainstream 'White' service providers, and resulted in a general reluctance to engage with or act on the advice these services provided.



Importantly however, we found that peer-led services like BAC-IN, where a strong sense of identification is evident in the experiences and ethnic backgrounds of staff and peers, offer an effective alternative approach to addressing addiction. This is for a number of reasons:

- a. Many of the underlying causes of addiction among BAME people can be found in cultural explanations, for example, cultural conflict and the need to 'fit in'. Cultural norms and the social acceptance of alcohol, for example, in some cultures were unlikely to be understood and possibly overlooked by those inhabiting different cultures.
- b. A lack of diversity and cultural knowledge among staff in mainstream services for drug and alcohol recovery was reported as preventing them from adequately understanding and meeting the needs of BAME people with addictions.

- c. The belief systems of some BAME communities were little-known or understood by mainstream service providers, and therefore they were ill equipped to provide appropriate support.

- d. Addiction is hidden in many BAME communities due to issues related to shame and stigma. Services with cultural knowledge of how shame/stigma manifests itself are arguably better placed to reach out to those people reluctant to engage with services.

This highlights the importance of ensuring that service providers have a thorough awareness of the cultural issues pertinent to specific BAME communities, and that culturally informed support is available for those who need it – whether specifically focused on addiction and recovery or for other associated issues including mental ill health.

### 3. WHAT WORKS FOR PEOPLE IN RECOVERY?

We found that the type of holistic and culturally tailored support provided by BAC-IN is effective for many people from BAME communities seeking recovery. A number of factors are central to this:

1. The focus on addressing and identifying a range of factors beyond addiction such as security of housing, education and employment are interrelated to recovery and are important for stability. Individuals experiencing chaos in their lives, perhaps with negative encounters with services in the past, are likely to find contact with multiple agencies challenging. Some lack agency and are unable to navigate the system (employment, benefits, education etc.) effectively without support and direct advocacy.
2. A consistent and personal contact with the service ensures that an individual builds trust

and does not experience the frustration of having to repeat their histories, challenges and needs to different people.

3. Recognition of the immediacy of need for support and responsiveness sets services such as BAC-IN apart from other agencies by operating out-of-hours, offering round-the-clock support, and not using waiting lists.

4. Identification between peers and service users (in terms of the lived reality of addiction, culture, ethnicity etc.) is fundamental to creating trust and encouraging disclosure, and subsequently, the uptake and maintenance of support networks.

5. Recognising that belief provides people with hope, so it is important that those who draw strength from religion and/or spirituality are encouraged and supported to draw on these as part of their recovery. A wealth of evidence substantiates that religion and spirituality are

central to the recovery of some BAME people, in that it helps to moderate behaviour and offers hope and purpose.

6. Support should aim to foster interdependency, rather than dependency. For example, we found that BAC-IN's WhatsApp group encouraged members to provide mutual support by posting positive affirmations, pointing people to information, and motivating them to attend recovery group meetings and appointments. Individuals articulated a sense of responsibility and 'purpose' in looking out for those new to recovery group sessions, and this was cited as good practice.

It is left up to the reader to consider whether and how these different factors are replicable in other contexts and communities, and why, in the experience of our research participants, these hallmarks of effective support represented the exception rather than the norm.

### Summary

Our research with BAC-IN – a small, peer-led drug and alcohol recovery service for BAME communities in Nottingham – has illustrated that a number of factors work concurrently to support recovery. Of most significance is the value of peer-led services (for, with and by people with experience of addiction), coupled with cultural responses where people's values, beliefs and experiences are widely understood from the point of initial contact.

Much of this learning is transferable to health and social care services for BAME communities beyond the fields of addiction and recovery. In all walks of life we frame our understandings based on the lens we apply and the lives we have lived; and this research has revealed that peer-led services with staff that reflect the cultures, backgrounds and experiences of service users can have a deeper and more sensitive understanding of the lived realities of those they aim to support. In turn, this can lead to greater uptake of support, sustained engagement and, in many cases, more positive outcomes.

## APPENDIX | SUMMARY OF RESEARCH PARTICIPANTS

Pseudonym	Age	Gender	Ethnicity	Location	Nature of Addiction	Mental ill-health diagnosis	What led to addiction
KULVINDER	40	M	British Indian	Derby (could not access a similar service in his own city)	Drugs & Alcohol	Depression	Recreational use (from age 20) in social circle spiralled out of control
DEAN	45	M	White & Black Caribbean	St Anns	Drugs (Crack cocaine, mamba, heroin)	Anxiety and Panic disorder	Involvement in gang, peer pressure, lack of engagement with education
CARL	32	M	Black Caribbean	Carlton	Drugs (cannabis, coke, speed, weed) & Alcohol	Diagnosed with paranoid schizophrenia at 21 (before addiction)	Started smoking cannabis at 15, trauma led to addiction. Also struggled with racism from childhood to adulthood.
STEVEN	29	M	British Indian	Basford	Drugs (Cannabis) & Alcohol	Depression. Mental ill-health diagnosed before addiction	Chaotic childhood: racism, exclusion, mental ill health
PATRICK	35	M	Black Caribbean	Basford	Taken cocaine & ecstasy but isn't addicted. He is addicted to alcohol	Psychosis	Trauma - losing a family member
DANIEL	28	M	White Irish	Mapperley	Drugs (Cocaine, cannabis, crack cocaine)	Depression and self-harm	Trauma - loss of a close friend
MASOOD	30	M	British Bangladeshi	North Notts	Drugs (cannabis, ecstasy, MDMA, cocaine)	Anxiety and Panic disorder	Taking and supplying drugs - trying to fit in with peers in a mainly White British school
STACEY	28	F	Dual heritage - West Indian and White British	Top Valley	Alcohol	Depression	Neglect, alcoholic mother, started drinking alcohol with peers
EDWARD	46	M	Dual heritage - West Indian and White British	Bakersfield	Drugs (Crack cocaine, ecstasy, speed, cocaine)	Anxiety and Panic disorder	Impact of absent father, racism, cultural conflict. drug-taking in peer group, which grew out of control
RAJAN	43	M	British Indian	Mapperley	Drugs (LSD, amphetamines, crack cocaine) & Alcohol	Mental ill-health diagnosed before addiction. Psychosis	Alcohol dependency since age 16 due to mental ill health and sexual abuse



# CULTURE, CONNECTION AND BELONGING:

A STUDY OF ADDICTION AND RECOVERY IN NOTTINGHAM'S BAME COMMUNITY



CONNECTED

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2 LIFE

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Chase**

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University**

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and Social Research**

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